FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

I. IDPH Facility ID Number: 0047621

Facility Name: South Elgin Rehabilitation & Health Care Center

Address: 746 West Spring Street (Number) South Elgin (City) 60177 (Zip Code)

County: Kane

Telephone Number: (847) 697-0565 **Fax #** (847) 697-0568

HFS ID Number: 20-3224201010

Date of Initial License for Current Owners: 10/1/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) McGladrey & Pullen, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	17	Skilled (SNF)	17	6,205	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,357	2,357	8
9	SNF/PED					9
10	ICF	14,531	3,149		17,680	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,531	3,149	2,357	20,037	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.03%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 2,357

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Ce # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	121,011	10,507	4,669	136,187		136,187	1,991	138,178			1
2	Food Purchase		87,596		87,596		87,596	(3,974)	83,622			2
3	Housekeeping	121,724	12,580		134,304		134,304	64	134,368			3
4	Laundry	9,055	8,214		17,269		17,269		17,269			4
5	Heat and Other Utilities			50,383	50,383		50,383	264	50,647			5
6	Maintenance	26,765	44,116	7,493	78,374		78,374	4,935	83,309			6
7	Other (specify):* Home Office Benefits							1,240	1,240			7
8	**TOTAL General Services**	278,555	163,013	62,545	504,113		504,113	4,520	508,633			8
	B. Health Care and Programs											
9	Medical Director			12,100	12,100		12,100		12,100			9
10	Nursing and Medical Records	931,621	234,253	43,758	1,209,632		1,209,632	6,149	1,215,781			10
10a	Therapy			197,746	197,746		197,746	473	198,219			10a
11	Activities	42,234	3,254		45,488		45,488		45,488			11
12	Social Services	70,361			70,361		70,361		70,361			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Benefits							1,935	1,935			15
16	**TOTAL Health Care and Programs**	1,044,216	237,507	253,604	1,535,327		1,535,327	8,557	1,543,884			16
	C. General Administration											
17	Administrative	73,718		59,500	133,218		133,218	(44,267)	88,951			17
18	Directors Fees											18
19	Professional Services			4,811	4,811		4,811	8,726	13,537			19
20	Dues, Fees, Subscriptions & Promotions			7,271	7,271		7,271	982	8,253			20
21	Clerical & General Office Expenses	29,067	6,257	19,768	55,092		55,092	28,395	83,487			21
22	Employee Benefits & Payroll Taxes			218,649	218,649		218,649	3,851	222,500			22
23	Inservice Training & Education											23
24	Travel and Seminar			150	150		150	735	885			24
25	Other Admin. Staff Transportation			14,620	14,620		14,620	2,161	16,781			25
26	Insurance-Prop.Liab.Malpractice			15,377	15,377		15,377	1,130	16,507			26
27	Other (specify):* Home Office Benefits							5,513	5,513			27
28	**TOTAL General Administration**	102,785	6,257	340,146	449,188		449,188	7,226	456,414			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,425,556	406,777	656,295	2,488,628		2,488,628	20,303	2,508,931			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center #0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			22,961	22,961		22,961	1,201	24,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,114	53,114		53,114	16,425	69,539			32
33	Real Estate Taxes			54,800	54,800		54,800	1,980	56,780			33
34	Rent-Facility & Grounds							901	901			34
35	Rent-Equipment & Vehicles			61,280	61,280		61,280	589	61,869			35
36	Other (specify):*											36
37	TOTAL Ownership			192,155	192,155		192,155	21,096	213,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,281	3,892	13,173		13,173		13,173			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* Nonallowable Cost			157,480	157,480		157,480	(157,480)				43
44	TOTAL Special Cost Centers		9,281	210,647	219,928		219,928	(157,480)	62,448			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,425,556	416,058	1,059,097	2,900,711		2,900,711	(116,081)	2,784,630			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,355)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,473)	30		9
10	Interest and Other Investment Income	(4,153)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(629)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(24,220)	43		18
19	Entertainment				19
20	Contributions	(167)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(98,256)	43		24
25	Fund Raising, Advertising and Promotional	(2,133)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(34,375)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (172,761)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	56,680		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 56,680		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (116,081)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

South Elgin Rehabilitation & Health Care Center

ID# 0047621

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Marketing Events	$ (3,575)	43	1
2	Labs - Part A	(17,442)	43	2
3	X-rays - Part A	(6,575)	43	3
4	Marketing Supplies	(1,129)	43	4
5				5
6				6
7	Offset Meal Revenue	(380)	2	7
8	Non-Allowable travel	(5,274)	24	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(34,375)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	1,425	0	566	0	0	0	0	0	0	0	1,991	1
2	Food Purchase	(380)	70	0	4	0	0	0	0	0	0	0	(306)	2
3	Housekeeping	0	63	0	1	0	0	0	0	0	0	0	64	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	264	0	0	0	0	0	0	0	0	0	264	5
6	Maintenance	0	3,623	0	1,312	0	0	0	0	0	0	0	4,935	6
7	Other (specify):*	0	571	0	669	0	0	0	0	0	0	0	1,240	7
8	**TOTAL General Services**	(380)	6,016	0	2,552	0	0	0	0	0	0	0	8,188	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,151	0	998	0	0	0	0	0	0	0	6,149	10
10a	Therapy	0	473	0	0	0	0	0	0	0	0	0	473	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,593	0	342	0	0	0	0	0	0	0	1,935	15
16	**TOTAL Health Care and Programs**	0	7,217	0	1,340	0	0	0	0	0	0	0	8,557	16
	C. General Administration													
17	Administrative	0	(45,457)	0	1,190	0	0	0	0	0	0	0	(44,267)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,151	0	2,576	0	0	0	0	0	0	0	8,727	19
20	Fees, Subscriptions & Promotions	0	603	0	379	0	0	0	0	0	0	0	982	20
21	Clerical & General Office Expenses	0	0	22,637	5,758	0	0	0	0	0	0	0	28,395	21
22	Employee Benefits & Payroll Taxes	0	0	183	0	0	0	0	0	0	0	0	183	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,274)	0	5,481	528	0	0	0	0	0	0	0	735	24
25	Other Admin. Staff Transportation	0	0	1,458	703	0	0	0	0	0	0	0	2,161	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,079	51	0	0	0	0	0	0	0	1,130	26
27	Other (specify):*	0	0	4,001	1,512	0	0	0	0	0	0	0	5,513	27
28	**TOTAL General Administration**	(5,274)	(38,703)	34,839	12,697	0	0	0	0	0	0	0	3,559	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,654)	(25,470)	34,839	16,589	0	0	0	0	0	0	0	20,304	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center **#** 0047621 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,473)	0	5,582	1,092	0	0	0	0	0	0	0	1,201	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,153)	0	3,100	17,478	0	0	0	0	0	0	0	16,425	32
33	Real Estate Taxes	0	0	655	1,325	0	0	0	0	0	0	0	1,980	33
34	Rent-Facility & Grounds	0	0	634	267	0	0	0	0	0	0	0	901	34
35	Rent-Equipment & Vehicles	0	0	332	257	0	0	0	0	0	0	0	589	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,626)	0	10,303	20,419	0	0	0	0	0	0	0	21,096	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(157,481)	0	0	0	0	0	0	0	0	0	0	(157,481)	43
44	**TOTAL Special Cost Centers**	(157,481)	0	0	0	0	0	0	0	0	0	0	(157,481)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(172,761)	(25,470)	45,142	37,008	0	0	0	0	0	0	0	(116,081)	45

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 1,425	$ 1,425	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	70	70	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	63	63	3
4	V								4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	264	264	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,623	3,623	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	571	571	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,151	5,151	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	473	473	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,593	1,593	10
11	V	17	Administrative	59,500	Petersen Health Care, Inc.	100.00%	14,043	(45,457)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,151	6,151	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	603	603	13
14	Total			$ 59,500			$ 34,030	$ * (25,470)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 22,637	$ 22,637	15
16	V	22	Employee Relations		Petersen Health Care, Inc.	100.00%	183	183	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	5,481	5,481	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,458	1,458	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,079	1,079	19
20	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,001	4,001	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,582	5,582	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	3,100	3,100	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	655	655	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	634	634	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	332	332	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 45,142	$ * 45,142	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 566	$ 566	15
16	V	2	Food		Petersen Health Care, Inc.	100.00%	4	4	16
17	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	1	1	17
18	V								18
19	V								19
20	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,312	1,312	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	669	669	21
22	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	998	998	22
23	V								23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	342	342	24
25	V	17	Administrative		Petersen Health Care, Inc.	100.00%	1,190	1,190	25
26	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,576	2,576	26
27	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	379	379	27
28	V	21	Clerical & General Office		Petersen Health Care, Inc.	100.00%	5,758	5,758	28
29	V								29
30	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	528	528	30
31	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	703	703	31
32	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	51	51	32
33	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,512	1,512	33
34	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,092	1,092	34
35	V	32	Interest		Petersen Health Care, Inc.	100.00%	17,478	17,478	35
36	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,325	1,325	36
37	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	267	267	37
38	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	257	257	38
39	Total			$			$ 37,008	$ * 37,008	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care C # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.88	1.76	Salary	$ 14,042	17,7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,042		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,141,463	56	$ 81,179	$ 80,967	20,037	$ 1,425	1
2	2	Food	Patient Days	1,141,463	56	3,989		20,037	70	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		20,037	63	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	14,545		20,037	255	5
6	6	Maintenance	Patient Days	1,141,463	56	161,683	77,787	20,037	2,838	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	18,226		20,037	320	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	113,737	110,642	20,037	1,997	8
9	10A	Therapy	Patient Days	1,141,463	56	2,112		20,037	37	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	12,703		20,037	223	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	20,037	14,043	11
12	19	Professional Services	Patient Days	1,141,463	56	288,162		20,037	5,058	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	24,538		20,037	431	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,149,628	872,054	20,037	20,180	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		20,037	183	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	300,453		20,037	5,274	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	68,745		20,037	1,207	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	26,422		20,037	464	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	191,964		20,037	3,370	19
20	30	Depreciation	Patient Days	1,141,463	56	124,736		20,037	2,190	20
21	32	Interest	Patient Days	1,141,463	56	176,614		20,037	3,100	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	35,254		20,037	619	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		20,037	634	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		20,037	332	24
25	TOTALS					$ 3,663,771	$ 1,941,450		$ 64,313	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,141,463	46	$	$	20,037	$	1
2	2	Food	Patient Days	1,141,463	46			20,037		2
3	3	Housekeeping	Patient Days	1,141,463	46			20,037		3
4	4	Laundry	Patient Days	1,141,463	46			20,037		4
5	5	Utilities	Patient Days	1,141,463	46	509		20,037	9	5
6	6	Maintenance	Patient Days	1,141,463	46	44,733	32,726	20,037	785	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	46	14,300		20,037	251	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	46	179,725	178,555	20,037	3,155	8
9	10A	Therapy	Patient Days	1,141,463	46	24,833		20,037	436	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	46	78,021		20,037	1,370	10
11				1,141,463						11
12	19	Professional Services	Patient Days	1,141,463	46	62,199		20,037	1,092	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	46	9,787		20,037	172	13
14	21	Clerical & General Office	Patient Days	1,141,463	46	139,995	82,268	20,037	2,457	14
15				1,141,463						15
16	24	Travel and Seminar	Patient Days	1,141,463	46	11,806		20,037	207	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	46	14,317		20,037	251	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	46	35,035		20,037	615	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	46	35,948		20,037	631	19
20	30	Depreciation	Patient Days	1,141,463	46	193,228		20,037	3,392	20
21	32	Interest	Patient Days	1,141,463	46	304,014				21
22	33	Real Estate Taxes	Patient Days	1,141,463	46	2,028		20,037	36	22
23										23
24										24
25	TOTALS					$ 1,150,478	$ 293,549		$ 14,859	25

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	427,669	46	$ 12,081	$ 11,958	20,037	$ 566	1
2	2	Food	Patient Days	427,669	46	93		20,037	4	2
3	3	Housekeeping	Patient Days	427,669	46	28		20,037	1	3
4										4
5										5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	20,037	1,312	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		20,037	669	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	20,037	998	8
9										9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		20,037	342	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	20,037	1,190	11
12	19	Professional Services	Patient Days	427,669	46	54,971		20,037	2,575	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		20,037	379	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	20,037	5,758	14
15										15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280		20,037	528	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		20,037	703	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		20,037	51	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265		20,037	1,512	19
20	30	Depreciation	Patient Days	427,669	46	23,301		20,037	1,092	20
21	32	Interest	Patient Days	427,669	46	373,049		20,037	17,478	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282		20,037	1,325	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		20,037	267	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		20,037	257	24
25	TOTALS					$ 789,885	$ 150,702		$ 37,007	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Ce # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	$ 460,000	$ 453,285	09/20/10	Varies	$ 39,111	1
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	90,000	89,835	09/20/10	0.1000	14,003	2
3												3
4							Allocated from Home Office				20,578	4
5							Offset Interest Income				(4,153)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 550,000	$ 543,120			$ 69,539	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 550,000	$ 543,120			$ 69,539	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center **#** 0047621 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		$ 54,760	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2005	$ 54,760	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **2006 Home Office Allocation**		1,980	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 56,780	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2001	8
	2002	9
	2003	10
	2004	11
	2005 54,760	12

Tax Accrual based on prior year tax bill

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Elgin Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047621

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309)691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-34-226-014	Nursing Home	$ 54,760.32	$ 54,760.32
2.		2006 Home Office Allocation	$	$ 1,979.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,760.32	$ 56,739.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,169 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	131,116	2005	$ 467,500	1
2					2
3	TOTALS	131,116		$ 467,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		2005	1970	$ ***	$		$	$	$	4
5											5
6	2006 Home Office Allocation			2006	11,950			523	523	523	6
7											7
8											8
	Improvement Type**										
9	Wheelchair			2006	15,515		25	310	310	310	9
10	Backflow Preve			2006	14,325		25	287	287	287	10
11	Walls			2006	3,550		25	71	71	71	11
12											12
13	Building Improvement Booked					1,018			(1,018)		13
14											14
15	2006 Home Office Allocation			2006	711			65	65	65	15
16											16
17											17
18											18
19											19
20											20
21	*** Note:										21
22	Facility was purchased as part of a multi-facility										22
23	sale. For purposes of allocating the purchase										23
24	price, appraisers valued the building and land										24
25	at the value of the bare land only. The allocated										25
26	amount appears on page 11 (Sch XI (A) line 1, column 4).										26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 46,051	$ 1,018		$ 1,256	$ 238	$ 1,256	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 91,621	$ 22,961	$ 14,459	$ (8,502)		$ 21,688	71
72	Current Year Purchases	34,233		2,361	2,361		2,360	72
73	Fully Depreciated Assets							73
74	2006 Home Office Allocation			6,086	6,086			74
75	TOTALS	$ 125,854	$ 22,961	$ 22,906	$ (55)		$ 24,048	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 639,405	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,979	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,162	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 183	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 25,304	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ N/A	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	2006 Home Office Allocation				901			5
6								6
7	TOTAL				$ 901 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 61,869 Description: Copier 3,504; Dishwasher 744; 2 Generators 3,447; Nsg Equip 53,585; Home Office Allocation 589
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A,3	hrs	$	786	$ 62,754	$	786	$ 62,754	1
2	Licensed Speech and Language Development Therapist	10A,3	hrs		99	8,536		99	8,536	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A,3	hrs		1,478	126,421		1,478	126,421	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				3,934		3,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	10A,3 & 39,2			1	35	5,347	1	5,382	13
14	TOTAL			$	2,364	$ 197,746	$ 9,281	2,364	$ 207,027	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2006 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 600	$ 600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	558,340	558,340	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,520	6,520	7
8	Accounts Receivable (owners or related parties)	22,447	22,447	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 587,907	$ 587,907	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	500,890	513,551	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	125,854	125,854	16
17	Accumulated Depreciation (book methods)	(23,563)	(25,304)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Special Deposit	1,850	1,850	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 605,031	$ 615,951	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,192,938	$ 1,203,858	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 452,192	$ 452,192	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,948	26,948	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,636	13,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,800	54,800	32
33	Accrued Interest Payable	5,670	5,670	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	15,356	15,356	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 568,602	$ 568,602	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	89,835	89,835	40
41	Bonds Payable	453,285	453,285	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 543,120	$ 543,120	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,111,722	$ 1,111,722	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 81,216	$ 92,136	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,192,938	$ 1,203,858	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

South Elgin Rehabilitation & Health Care Center
FYE: 12/31/06
Provider # 0047621

Schedule 17A

Other Current Liabilities(specify):

Line 36	Operating	After Consolidation
Fica W/h & Empl Fica	5,351	5,351
Federal Withholding	6,388	6,388
State W/h - IL	3,746	3,746
Wage Garnishment	359	359
Other Withholding	54	54
Acc Ins - Gen	(700)	(700)
Accrued Insurance - Health	157	157
	15,356	15,356

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 40,655	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 40,655	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	40,560	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 40,561	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 81,216	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,319,763	1
2	Discounts and Allowances for all Levels	52,625	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,372,388	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	288,515	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 288,515	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	98,247	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	380	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,855	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	34,822	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 275,304	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,153	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,153	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	613	28
28a	Miscellaneous	298	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 911	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,941,271	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	504,113	31
32	Health Care	1,535,327	32
33	General Administration	449,188	33
	B. Capital Expense		
34	Ownership	192,155	34
	C. Ancillary Expense		
35	Special Cost Centers	170,653	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,900,711	40
41	**Income before Income Taxes (line 30 minus line 40)****	40,560	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 40,560	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,387	1,387	$ 73,890	$ 53.28	1
2	Assistant Director of Nursing	285	285	22,563	79.10	2
3	Registered Nurses	8,423	8,471	233,285	27.54	3
4	Licensed Practical Nurses	6,881	6,993	175,663	25.12	4
5	CNAs & Orderlies	36,205	36,436	399,052	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,905	2,009	42,234	21.02	9
10	Activity Assistants					10
11	Social Service Workers	4,114	4,114	70,361	17.10	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,000	29,319	14.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,664	10,750	91,692	8.53	15
16	Dishwashers					16
17	Maintenance Workers	2,077	2,077	26,765	12.89	17
18	Housekeepers	13,884	13,993	121,724	8.70	18
19	Laundry	1,256	1,256	9,055	7.21	19
20	Administrator	1,214	1,214	73,718	60.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,075	2,082	29,067	13.96	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coordin	909	909	27,168	29.89	33
34	TOTAL (lines 1 - 33)	93,280	93,975	$ 1,425,556 *	$ 15.17	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	113	$ 4,669	1,3	35
36	Medical Director	monthly	12,100	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,327	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologoist Consultant	monthly	1,200	10,3	47
48					48
49	TOTAL (lines 35 - 48)	113	$ 19,296		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	75	$ 4,194	10,1	50
51	Licensed Practical Nurses	694	37,037	10,1	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	769	$ 41,231		53

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Duane Myers	Administrator	0	$ 24,065
Tom Stephenson	Administrator	0	24,522
Renee Bogard	Administrator	0	25,131
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,718

B. Administrative - Other

Description	Amount
Management Fee Expenses (fee eliminated on Col. 7)	$ 59,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 59,500

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin and Glasser, LLP	Accounting	$ 1,600
LTC Solutions	Computer Services	3,170
AT&T	Computer Services	41
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,811

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,800
Unemployment Compensation Insurance	76,670
FICA Taxes	105,553
Employee Health Insurance	2,425
Employee Meals	3,668
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,384
TOTAL (agree to Schedule V, line 22, col.8)	$ 222,500

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,303
Advertising: Employee Recruitment	3,665
Health Care Worker Background Check (Indicate # of checks performed 123)	1,480
Patient Background Checks	0
Miscellaneous Dues and Subscriptions	823
2006 Home Office Allocation	982
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,253

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	150
2006 Home Office Allocation	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 885

* Attach copy of IMRF notifications

**See instructions.

Petersen Health Care, Inc. (South Elgin)
Provider Number - 0047621
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		4,811
Allocated from Home Office		
Other Professional Fees	6,068	
Legal	82	
Other Professional Fees - PHO	2,499	
Legal - PHO	77	
		8,726
Total (agree to Schedule V, line 19, column 8)		13,537

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5								N/A					
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **20,853** Line **10A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **49,275**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **3,668** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **380**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Co** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees